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February 17, 2011

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Statement
Of
Anthem Blue Cross and Blue Shield
On
SB 11 An Act Concerning The Rate Approval Process For Health Insurance Policies
Before the
Insurance and Real Estate Committee

Anthem appreciates the opportunity to offer our comments about **SB 11 An Act Concerning the Rate Approval Process for Health Insurance Policies.**

To begin, Anthem Blue Cross and Blue Shield in Connecticut cares deeply about our Connecticut customers and our community and we share concerns about the rising costs of health care services and the corresponding increases in the cost of health insurance coverage, especially in this challenging economy. We also support the goal of this legislation to make the rate review and approval process more transparent and open to the consumer. However, we also feel it is important to state that health insurance rate increases reflect the fact that health care costs continue to escalate faster than the growth of premiums. As provider prices and consumer utilization increase, so must health insurance premiums. If insurers are unable to price premiums to adequately cover these increased costs, they become unable to pay claims on behalf of their members. It is important to remember this basic insurance principle as the committee deliberates action on legislation seeking to regulate the health insurance rate approval process.

The legislature has already provided the Insurance Department with the discretionary authority to hold rate hearings which permits the public to be heard and those persons with standing to participate in the hearing, including the right to cross-examine as we have seen with recent Anthem applications. The legislature has already articulated the actuarial standards against which a rate application must be judged. The Insurance Department has availed itself of its authority in specific circumstances when it has called for hearings.

We also believe it is important to note that when this legislation was submitted during the last legislative session, the Patient Protection and Affordable Care Act ("**PPACA**"), federal healthcare reform, had not passed. And when it did pass on March 23, 2010 it contained several components regarding rate review and rate approval processes. The following provisions took effect in 2010 under PPACA:

- **Annual rate review** ((section 2794(a)(1)) where the Department of Health and Human Services ("HHS") and states would immediately (2010) set up a process for annual review of "unreasonable increases" in premiums.
- **Prior justification of rates** ((section 2794(a) (2)) where before implementing any "unreasonable increases," insurers have to provide justification of their rates to HHS and states.
- **Mandatory publication of rate justifications** ((section 2794(a)(2)) where insurers would be required to post rate on their plan websites their justifications for the "unreasonable increases" and HHS would "ensure public disclosure."
- **Grants for premium review** (section 2794(b)(1)) where states would be given $250 million in grants to fund their reviews of premiums. Connecticut used its funds to set up an internet site where rate filings and all supporting documentation are available to the public. To date, Anthem has filed two rate requests that are available through the Department's website.
- **State reporting requirement** (section 2794(b)(1)) where states participating in the grant program would report to HHS about premium increase trends and, based on that information, make recommendations to HHS on which insurers to include in the exchanges.
- **Limits on medical loss ratio ("MLR")** (section 2718(b)(1)) which includes a MLR of 80% in the individual and small group markets, 85% in the large group market (or higher % set by states). Starting 2011, requires loss ratio reporting for MLRs below required levels. Applies to new and grandfathered plans.
- **Consumer rebates** (section 2718(b)(1)) where consumer rebates are required if MLR standards are not met.

The following provisions become effective in 2014:

- **Detailed federal rating rules** (section 2701) where all premiums will be community-rated (no health status adjustments), premium variations limited to age, family size, tobacco use, and geography.
- **Premium increases can lead to Exchange exclusion** (section 1311(e)(2)) where Exchanges are required to consider the reasonableness of premium increases when deciding plan participation.
- **Mandatory rate review comparison inside/outside Exchanges** (section 2794(b)(2)) starting in 2014, HHS and states would begin comparing premium increase trends in Exchange plans vs. non-Exchange plans.
- **Justification of any rate increase** (section 1311(e)(2)) where plans would have to submit justification to the Exchanges for any premium increase ("reasonable" or not) prior to implementation.
- **Mandatory publication of any rate increase and justification** (section 1311(e)(2)) where plans must post rate increases and justifications on their websites.
- **Rate increase justifications can impact Exchange inclusion or exclusion** (section 1311(e)(2)) where justifications help determine whether to include or exclude plans.
- **Mandatory transparency** (section1303(e)(3)) where transparency requirements are placed on reporting cost-sharing, claims payment, denials, rating, and finances.

As you can see from the long list of PPACA provisions related to rate review and justification of rates, any potential issues have been addressed. To pass state legislation with provisions in conflict with PPACA would set up a dynamic in which separate requirements would need to be met to reach the same goal. This direction would serve only to increase the administrative burden on the Insurance Department, health plans and, ultimately, costs to the purchasers of healthcare coverage.

We thank the Committees for the opportunity to comment on this legislation, and we are available to assist legislators in their deliberation of this legislation and to provide further information.